DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/20/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nia	00	COMPL	ETED
			A. BUILD	ING		05/07/	2013
			B. WING	CED FEET A	DDDEGG CVTV CTATE GD CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
OL IN AN AUT	DI AGENNEGE				SSION DR		
SUMMIT	PLACE WEST			INDIAN	APOLIS, IN 46214		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	•	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	Pl	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000000							
	This visit was f Licensure Survey dates: Facility number Provider number AIM number: If Survey team: Lora Brettnach Heather Lay, F Census bed ty Residential: 6: Total: 61 Census by pay Other: 61 Total: 61 Sample: 7 These state finaccordance with	for a State Residential vey. May 6 & 7, 2013 r: 011840 per: 011840 N/A rer, RN-TC RN pe: 1 ror source: rdings are cited in th 410 IAC 16.2. completed on May 8,	R000		Submission of this plan of correction does not constitute admission or agreement by th provider of the truth of facts alleged or correction set forth the statement of deficiencies. This plan of correction is prepared and submitted as a requirement under state and federal law. Please accept this as our crecallegation of compliance.	e on	DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: H69411 Facility ID: 011840 If continuation sheet Page 1 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JETIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
			B. WING	3		05/07/	2013
			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			55 N MI	SSION DR		
SUMMIT	PLACE WEST				APOLIS, IN 46214		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000033	(h) The facility muthe following: (1) A statement the complaint with the resident abuse, no resident property, facility. (2) The most receive telephone number (A) The departmen (B) The office of the social services. (C) The ombudshed division of disabilities services. (D) The area agent (E) The local mere (F) Adult protective. The addresses are this subdivision of accessible to resident appropriate. Based on obsetthe facility failed of state agencies number for filing resident abuse misappropriation and other practical state Department This deficient per findings including the facility failed of the residents residents residents residents residents residents residents residents including the facility failed of the facility f	ast furnish on admission at the resident may file a director concerning eglect, misappropriation of and other practices of the ently known addresses and rs of the following: ent. The secretary of family and man designated by the fity, aging, and rehabilitation may on aging. Intal health center. The services. The telephone numbers in hall be posted in an area dents and updated as trivation and interview, do to ensure a posting the included a toll free the gray a complaint of the neglect, the noting resident property, tices with the Indiana tent of Health (ISDH). The actice affected 61 of the siding in the facility. The sident property the siding in the facility. The sident of the siding in the facility. The sident of the siding in the facility.	R00	0033	I. Upon discovery, facility posted the toll free num for filing a complaint of residen abuse, neglect, misappropriation of resident property and other practices. II. As all residents cobe affected, the facility has take the following corrective actions III. The toll free number was posted and residents will informed per group meeting of the whereabouts/availability of toll free number and instruction for filing a complaint with the Indiana State Department of Health. IV. As a means of qual	uld en s. r be	05/16/2013
	iacinty was iffili	alca with the			iv. As a means of qual	ıty	

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/07/2013
	PROVIDER OR SUPPLIER PLACE WEST	55 N M	ADDRESS, CITY, STATE, ZIP CODE ISSION DR IAPOLIS, IN 46214	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance Supervisor. At that time, a posting of state agencies, addresses, and phone numbers was observed in the main entrance of the facility. The posting did not indicate how to contact ISDH or provide the toll free complaint hotline number. On 5/7/13 at 10:00 A.M., in an interview, the Administrator indicated there were no postings with the complaint hotline toll free number or how to file a complaint with the ISDH.		assurance, the Administrator shall conduct review of postin during weekly rounds, in an eto confirm that all required numbers/information remains posted for resident access.	igs ffort

State Form Event ID: H69411 Facility ID: 011840 If continuation sheet Page 3 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		05/07/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			IISSION DR	
SUMMIT	PLACE WEST			NAPOLIS, IN 46214	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R000150	410 IAC 16.2-5-1. Sanitation & Safe -Noncompliance (g) Each facility sconcerning pets. Based on interverview, the faci policy regarding of 3 pets house. During an interversident of 3 pets house. During an interversidents who concerning an interversidents who concerned was asked to proving an interversident of the pets current vaccination. Cethis cat had a repanleukopenia, and feline calically 3/23/2009, and expired on 3/23 unable to provincat had received vaccinations. The facility's current vaccinations.	ty Standards hall have a policy view and record lity failed to follow their g pet vaccinations for 1 ed in the facility. view on 5/6/2013 at e Executive Director the facility had three by by by by by by by by by rovide documentation rent vaccination view on 5/7/2013 at e ED indicated, he was de documentation of ations for a resident's ent titled, "Rabies entificate" indicated, abies, feline g feline rhinotracheitis, ivrus vaccination on those vaccination on those vaccination s 3/2010. The ED was de documentation this ed it's required current urrent pet policy dated was reviewed on	R000150	I. Upon discovery, resident secured an appointm for vaccinations to be obtained II. It was confirmed thall other pets housed within the facility were current with requivaccinations. III. In an effort to ensure ongoing compliance, the vaccination schedules were placed on a calendar. The Administrator or designee will monitor to remind residents of need for annual vaccinations in an effort to remain compliant of the maintaining documentation of current vaccinations for pets residing in the facility. Any new added pets shall be added to vaccination schedules accordingly. IV. As a means of qualess assurance, the Administrator of maintain records of said vaccinations and verify with the resident annual vaccinations a obtained once reminded, and obtain records of the same.	the ent d. hat e red re lity will le
	5/7/2013 at 10:	45 A.M. The policy	1		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COMI	E SURVEY PLETED 7/2013
	ROVIDER OR SUPPLIER		55 N M	ADDRESS, CITY, STATE, ZIP (ISSION DR IAPOLIS, IN 46214	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COD (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	facility shall ha examinations a immunizations	Any pet housed in the ve periodic veterinary and required in accordance with health regulations				

State Form Event ID: H69411 Facility ID: 011840 If continuation sheet Page 5 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DING	00	COMPL	ETED
			A. BUII			05/07/	2013
			B. WIN		ADDRESS STATE STATE STATE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
OLINANAIT	DI AGE MEGT				ISSION DR		
SUMMIT	PLACE WEST			INDIAN	APOLIS, IN 46214		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000349	410 IAC 16.2-5-8	.1(a)(1-4)					
	Clinical Records -	- Noncompliance					
	(a) The facility mu	ust maintain clinical records					
		These records must be					
		the supervision of an					
		acility designated with that					
	•	e records must be as					
	follows:						
	(1) Complete.(2) Accurately do	oumanted.					
	(3) Readily acces						
	(4) Systematically						
	Based on reco		ROC	0349	I. Regarding Resid	ont	05/16/2013
			Itot	103 1 7	I. Regarding Resident Half, employees who document		03/10/2013
		acility failed to ensure			administration at 9 a.m., when		
	•	accurate clinical			fact the medication had been	,	
		naintained regarding			administered upon return from		
	medication adn	ninistration [Resident			dialysis (as ordered), were		
	#1] and laborat	ory testing [Resident			re-educated as to correct		
	#6]. This defici	ient practice affected 2			documentation of medication		
	-	eviewed for physician			administration times. Regardin		
		ications and laboratory			Resident #6, the physician wa	S	
		ications and laboratory			notified of the omitted PT/INR		
	testing.				and further physician orders w	III	
					be followed accordingly. II. As all residents co	uld	
	Findings includ	e:			be affected, the orders for all	uiu	
					residents will be reviewed to		
	1. On 5/6/13 a	t 11:15 A.M., Resident			ensure any specific directives		
	#1's record was	s reviewed. Diagnoses			regarding timing of medication		
		rere not limited to,			administration are being follow		
	· ·	depression, dementia,			and documented accordingly.		
	* -	nal failure. Resident			physician orders received with		
	•				the past 30 days have again b	een	
		modialysis three times			reviewed to ensure compliance	Э	
	per week.				therewith.		
					III. As a means to ensu	ire	
	A "Physician's	Order" dated 7/27/12,			ongoing compliance, licensed	:	
	included, but w	as not limited to, "Hold			staff will receive inservice train	•	
	•	g] medications on			addressing following physician orders as well as correct		
	- '	Administer upon			documentation of medication		
	ulalysis uays	Autilitiolei uputi	l		uocumentation of medication		

State Form Event ID: H69411 Facility ID: 011840 If continuation sheet Page 6 of 11

NAME OF PROVIDER OR SUPPLIER SUMMIT PLACE WEST (N4) ID SUMMARY STATIMENT OF DEFICIENCIES (N5) IN INSISION DR INDIANAPOLIS, IN 46214 (N5) PREFEX GEACH DEFICIENCY MUST BE PRECEDED BY PILL TAG RECULATORY OR I.SC IDENTIFYING INFORMATION) A "Medication Record" dated 3/1/13 through 3/31/13, included the following 9:00 A.M. medications: Plavix [anti-platelet aggregate], Synthroid [thyroid hormone replacement], Coreg [anti-hypertensive], Keppra [anti-convulsant], and Renvela [phosphate binder]. All medications were marked as given at 9:00 A.M. on 3/1/13 through 4/30/13 included the following 9:00 A.M. medications: Plavix [anti-platelet aggregate], Synthroid [thyroid hormone replacement], Coreg [anti-hypertensive], Keppra [anti-convulsant], and Renvela [phosphate binder]. All medications were marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given at 9:00 A.M. on 4/1/13 through 4/30/13	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
NAME OF PROVIDER OR SUPPLIER SUMMIT PLACE WEST SIRRET ADDRESS, CITY, STATE, ZIP CODE. 55 N MISSION DR NDIANAPOLIS, IN 46214 SEGULATORY OR IS CIDENTEYING INFORMATION return" A "Medication Record" dated 3/1/13 through 3/31/13, included the following 9:00 A.M. medications: Plavix [anti-choruslast], and Renvela [phosphate binder]. All medications were marked as given at 9:00 A.M. on 3/1/13 through 3/31/13. A "Medication Record" dated 4/1/13 through 4/30/13, included the following 9:00 A.M. medications were marked as given at 9:00 A.M. on 3/1/13 through 3/31/13. A "Medication Record" dated 4/1/13 through 4/30/13, included the following 9:00 A.M. medications: Plavix [anti-choruslast], and Renvela [phosphate binder]. All medications were marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given on 4/1, 4/2, 4/3, and 4/4]. There was no documentation that the above morning medications were held on dialysis days [Tuesday, Thursday, and Saturday]. On 5/7/13 at 10:15 A.M., the Director	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING 00 COMPLETED			ETED		
NAME OF PROVIDER OR SUPPLIER SUMMIT PLACE WEST INDIANAPOLIS, IN 46214 SIMMARY STATEMENT OF DEFICIENCIES S N MISSION DR INDIANAPOLIS, IN 46214 IRECRACTORY OR ISCUBRITERING INFORMATION) FEUT" IRECRACTORY OR ISCUBRITERING INFORMATION) A "Medication Record" dated 3/1/13 through 3/31/13, included the following 9:00 A.M. medications: Plavix [anti-convulsant], and Renvela [phosphate binder]. All medications were marked as given at 9:00 A.M. on 3/1/13 through 3/31/13. A "Medication Record" dated 4/1/13 through 4/30/13, included the following 9:00 A.M. medications: Plavix [anti-convulsant], and Renvela [phosphate binder]. All medications: Plavix [anti-platelet aggregate], Synthroid [thyroid hormone replacement], Coreg [anti-hypertensive], Keppra [anti-convulsant], and Renvela [phosphate binder]. All medications: Plavix [anti-platelet aggregate], Synthroid [thyroid hormone replacement], Coreg [anti-hypertensive], Keppra [anti-convulsant], and Renvela [phosphate binder]. All medications were marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given on 4/1, 4/2, 4/3, and 4/4]. There was no documentation that the above morning medications were held on dialysis days [Tuesday, Thursday, and Saturday]. On 5/7/13 at 10:15 A.M., the Director					W		05/07/2013		
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return" A "Medication Record" dated 3/1/13 through 3/31/13, included the following 9:00 A.M. medications: Plavix [anti-platelet aggregate], Synthroid [thyroid hormone replacement], Coreg [anti-hypertensive], Keppra [anti-convulsant], and Renvela [phosphate binder]. All medications were marked as given at 9:00 A.M. on 3/1/13 through 4/30/13, included the following 9:00 A.M. medications: Plavix [anti-platelet aggregate], Synthroid [thyroid hormone replacement], Coreg [anti-hypertensive], Keppra [anti-convulsant], and Renvela [phosphate binder]. All medications were marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given on 4/1, 4/2, 4/3, and 4/4]. There was no documentation that the above morning medications were held on dialysis days [Tuesday, Thursday, and Saturday]. On 5/7/13 at 10:15 A.M., the Director		· ·				CROSS-REFERENCED TO THE APPROPRIA	TE		
A "Medication Record" dated 3/1/13 through 3/31/13, included the following 9:00 A.M. medications: Plavix [anti-platelet aggregate], Synthroid [thyroid hormone replacement], Coreg [anti-hypertensive], Keppra [anti-convulsant], and Renvela [phosphate binder]. All medications were marked as given at 9:00 A.M. on 3/1/13 through 4/30/13, included the following 9:00 A.M. medications: Plavix [anti-platelet aggregate], Synthroid [thyroid hormone replacement], Coreg [anti-hypertensive], Keppra [anti-convulsant], and Renvela [phosphate binder]. All medications: Plavix [anti-platelet aggregate], Synthroid [thyroid hormone replacement], Coreg [anti-hypertensive], Keppra [anti-convulsant], and Renvela [phosphate binder]. All medications were marked as given at 9:00 A.M. on 4/1/13 through 4/30/13 except Renvela [marked as given on 4/1, 4/2, 4/3, and 4/4]. There was no documentation that the above morning medications were held on dialysis days [Tuesday, Thursday, and Saturday]. On 5/7/13 at 10:15 A.M., the Director	TAG		LSC IDENTIFYING INFORMATION)	T.	AG	·		DATE	
LOCOMO SOUR DOUGO DE LI DESIGERE LA COMPANIO DE LA COMPANIO DEL COMPANIO DEL COMPANIO DE LA COMPANIO DE LA COMPANIO DE LA COMPANIO DEL COMPANIO DEL COMPANIO DEL COMPANIO DE LA COMPANIO DEL COMPANION DEL COMPANIO DEL COMPANION DEL COMPANIO	TAG	return" A "Medication through 3/31/1 following 9:00 Plavix [anti-pla Synthroid [thyr replacement], [anti-hypertens [anti-convulsar [phosphate bir were marked a 3/1/13 through A "Medication through 4/30/1 following 9:00 Plavix [anti-pla Synthroid [thyr replacement], [anti-hypertens [anti-convulsar [phosphate bir were marked a 4/1/13 through Renvela [mark 4/3, and 4/4]. There was no above morning on dialysis day and Saturday].	Record" dated 3/1/13 3, included the A.M. medications: Itelet aggregate], Ioid hormone Coreg Sive], Keppra Int], and Renvela Ider]. All medications Is given at 9:00 A.M. on 3/31/13. Record" dated 4/1/13 3, included the A.M. medications: Itelet aggregate], Ioid hormone Coreg Sive], Keppra Int], and Renvela Ider]. All medications Is given at 9:00 A.M. on 4/30/13 except Ided as given on 4/1, 4/2, Idocumentation that the Ig medications were held Is [Tuesday, Thursday, Identications Interpretation that the Ig medications were held Is Interpretations Interpretation that the Ig medications were held Is Interpretation that the Ig medication that the Ig medication were held Is Interpretation that the Ig medication that the I	T	AG	administration. IV. As a means of qual assurance, the DON or design will review all newly received orders on scheduled days of wand will verify compliance with correct transcription and execution of ordered labs/diagnostics, as well as review medication administration records for compliance with correct documentation of administration should the medication be ordered at time other than routine medication administration times. Should non-compliance be noted, statishall be addressed and	vork on	DATE	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMPI 05/07	LETED
	PROVIDER OR SUPPLIEI	3	55 N MI	NDDRESS, CITY, STATE, ZIP COD SSION DR APOLIS, IN 46214	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	He indicated s dialysis between P.M In additisince Resident dialysis within timeframe for a scheduled 9:00 actual time the were given shouther medication. He indicated in accurately documedications or 2. On 5/6/13 a #6's record was included, but wheart valve representation and #6 was dischationally 4/15/13 for rehabitation of the indication of the indications or 2. On 5/6/13 a modications or 3/16's record was included, but wheart valve representation and #6 was dischationally 4/15/13 for rehabitational for the indicated put with the indicated provided p	con return from dialysis. The returned from the new 11:00 A.M. to 1:00 on, the DoN indicated to the new 14 did not return from the new 15 an acceptable administration of the new 15 a.M. medications, the new 16 morning medications to the new 16 morning medications to the new 16 morning				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/20/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING B. WING	COMPLETED 05/07/2013
NAME OF PROVIDER OR SUPPLIER SUMMIT PLACE WEST	STREET ADDRESS, CITY, STATE, ZIP COD 55 N MISSION DR INDIANAPOLIS, IN 46214	Е
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY F TAG REGULATORY OR LSC IDENTIFYING INFORMA'	ULL PREFIX (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	LD BE COMPLETION
On 5/7/13 at 10:00 A.M., the Director of Nursing indicated the facility failed to complete the PT/INR that was ordered on 3/13/13.	or	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JETIPLE CO	DNSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
			B. WING	<u> </u>		05/07/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SUMMIT	PLACE WEST				ISSION DR APOLIS, IN 46214		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000410	completed within admission or upo forty-eight (48) to The result shall be induration with the and by whom adr (f) For residents with documented negative result during the promoths, the base should employ the first step is negative be performed with weeks after the fir repeat testing will infection with tube (g) All residents with the tuberculin sto have a chest xelaboratory examinal diagnosis. Based on reconsinterview, the farm resident's and test was complested a resident's and test was complested 1 of 7 tuberculosis so Findings included. On 5/6/13 at 10 #4's record was included, but with the first record was included.	- Noncompliance suberculin skin test shall be three (3) months prior to n admission and read at seventy-two (72) hours. e recorded in millimeters of e date given, date read, ninistered and read. who have not had a ative tuberculin skin test preceding twelve (12) line tuberculin skin testing e two-step method. If the eve, a second test should nin one (1) to three (3) rest test. The frequency of depend on the risk of erculosis. Who have a positive reaction eskin test shall be required eray and other physical and nations in order to complete and review and acility failed to ensure nual tuberculin skin eted per the Indiana ent of Health is deficient practice residents reviewed for reening [Resident #4].	R00	0410	I. Resident #4 received annual mantoux testin upon observance of the oversi II. The medical record of all residents were reviewed confirm timely annual testing h been conducted and recorded. III. As a means to ensu ongoing compliance, the DON designee shall maintain an ongoing monthly calendar of annual mantoux testing and ve the completion of said testing of a monthly basis. IV. As a means of qual assurance, the DON or design shall report to the Administrato on a monthly basis those	ght. ds to ead or erify on ity ee	05/16/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		05/07/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	t.		ISSION DR	
SUMMIT	PLACE WEST			IAPOLIS, IN 46214	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	alcohol depend	dency.		residents due annual mantoux testing and completion thereo	
	Δ Mantoux Itub	perculin skin test]			
	_	d, but was not limited			
		ests: Date given:			
		read: 3/8/12 Results:			
	0 millimeters	"			
	There was no	documentation in			
	Resident #4's				
		perculin skin test for			
	•	CICUIII SKIII LESE IUI			
	March, 2013.				
	On 5/7/13 at 9 ⁻	30 A.M., the Director			
		cated the facility failed			
	-	Resident #4's yearly			
		• •			
		test. He indicated			
		as administered the			
	tuberculin skin	test on 5/6/13.			
				1	

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